Western DuPage Special Recreation Association.
116 N. Schmale Rd. Carol Stream, IL 60188 630.681.0962 Fax: 630.681 1262

Medication Dispensing Form / Waiver

1. Each medication must be in the original container from the pharmacy.
2. The container must have the original prescription label, which includes: Doctor's name, patient's name, pharmacy, medication, strength, dosage and date.
3. This form must be completed prior to the program. You may give this form and medication directly to the Head Instructor or Driver at the program. Please do not put in participant's bag.
4. There will be no exceptions unless pre-arranged with the program Coordinator / Head Instructor.

Participant's Name:_____ Date of Birth _____/_____/_____

Medication	Dosage	AM	Noon	Dinner	Bedtime	Notes

Prescribing Physician:_____

Primary Physician's Phone #:_____

Pharmacy & Phone Number:_____

Please circle the following: **How is the medication taken?**

Whole Chewed With food Without Food Other_____

Mixed With Food With water Without Water

Please list any side effects:_____

Does the participant take any over-the-counter pain relievers or anti-acids? Yes No

Is the participant allergic to any medication? _____

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medications to my minor child or adult. In consideration of the WDSRA administering medications to my minor child or adult, I do hereby fully release or discharge WDSRA and its officers, agents and employees from any and all claims from injuries, damages and losses I or my minor child or adult in any way associated with the administering of medication. If after administering medication, there is an adverse reaction, I give permission to WDSRA to secure from any licensed hospital or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

_____ _____/_____/_____

Signature of Parent or Guardian **Date**